MEDICARE BENEFICIARY PROTECTION AMENDMENTS OF 1995

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 24, 1995

Mr. STARK. Mr. Speaker, I am pleased to introduce the Medicare Beneficiary Protection Amendments of 1995. I am joined by Mr. WAXMAN, Mr. ACKERMAN, Mr. COYNE, Mr. DELLUMS, Mr. FOGLIETTA, Mr. GONZALEZ, Mr. KENNEDY of Rhode Island, Mr. MCDERMOTT, Mr. OLVER, Mr. PALONE, Ms. PELOSI, Mr. RANGEL, and Ms. WOOLSEY.

This legislation is designed to achieve what its title implies—to improve the protections provided to Medicare beneficiaries. This legislation is urgently and increasingly needed, for two chief reasons.

First, proposals are appearing that have as their focus the movement of more and more Medicare beneficiaries into managed care insurance products. Some proposals would push beneficiaries into health maintenance organizations. I support a less coercive approach, one that allows beneficiaries to determine the pace at which they move into HMO's. But either way, HMO's will continue to play a growing role in Medicare.

Second, an extensive survey of Medicare HMO enrollees and former enrollees, recently completed by the inspector general of the Department of Health and Human Services, documents several problem areas with Medicare HMO's. The inspector general's findings substantiate numerous complaints I have received from individual beneficiaries over the past few years.

It is clear that before Congress flings the Medicare doors wide open to managed care plans, we ought to act to prohibit managed care practices that are known to jeopardize beneficiary care. And we ought to act swiftly, because this is an area where an ounce of prevention is worth more than a pound of the cure.

The summary finding of the inspector general's report, I believe, captures very well the overall experience we are having with the service delivery of Medicare HMO's:

> Generally, beneficiary responses indicated Medicare risk HMOs provide adequate service access for most beneficiaries who have joined. However, our survey results also indicated some problem areas: beneficiaries' knowledge of appeal rights, access and service to [end stage renal disease]/disabled beneficiaries, and inappropriate screening of beneficiaries health status at application.

Overall, Medicare beneficiaries are receiving adequate services, but serious problems exist with a significant number of enrollees, particularly among those enrollees who have the greatest health care needs. Some of the specific findings of the inspector general are:

> [C]ompliance with Federal enrollment standards for health screening and informing beneficiaries of their rights appeared to be problematic.
>
> Most beneficiaries reported timely doctor appointments for primary and specialty care, but some enrollees and disenrollees experienced noteworthy delays.
>
> Perceived, unmet service needs and lock-in problems led 22% of disenrollees and 7% of enrollees to seek out-of-plan care.
>
> Disabled/ESRD [end stage renal disease] disenrollees . . . reported access problems in several crucial areas of their HMO care.

In addition, the inspector general's survey found that:

> 16% [of enrollees] either planned to leave or wanted to leave [their HMO], but felt they could not, primarily for reasons of affordability.

The most troubling of the inspector general's findings is that:

> 66% of disabled/ESRD enrollees wanted to leave their HMOs.

I have no illusions that the "Medicare Beneficiary Protection Amendments of 1995" will completely alleviate all of these problems. In fact, I am hopeful that consumers, providers, and others will continue to offer suggestions as to how we can continue to improve the quality of care received by Medicare beneficiaries. Nonetheless, the remedies I am proposing today will take us a long way toward that goal.

In addition to providing specific responses to managed care practices that have created beneficiary access problems, this legislation provides a framework through which Medicare beneficiaries can make informed choices about their Medicare coverage options.

Too often today, while a beneficiary has the legal right to exit an HMO and return to traditional Medicare coverage, the inability to secure an affordable Medicare supplemental policy—a medigap plan—makes this a hollow option. As proposed in this legislation, the institution of a coordinated open enrollment process for Medicare beneficiaries will guarantee that the options we claim to provide to beneficiaries are actually open to them.

Central to the functioning of the coordinated open enrollment process—and to guaranteeing true choice for beneficiaries—is the beginning of attained-age pricing of medigap premiums. Attained-age pricing is the policy of raising medigap premiums as an enrollee gets older. In their report on medigap plans, Consumer Reports magazine described attained-age priced plans as hazardous to policyholders. I agree.

A comparison of the least expensive attained-age rated medigap plan versus the only community-rated medigap plan in California—using plan E for the comparison—showed that a typical Medicare beneficiary will pay $3,360 more for the attained-age plan than the community-rated plan over his or her life. On top of being more expensive, this attained-age rated plan restricted access to a limited number of health care providers. The reason for the higher lifetime premium is that while the attained-age plan starts with a lower premium, the premium quickly rises as the beneficiary ages to well above the non-age-adjusted community rate.

The premium comparison follows:

MEDICARE SUPPLEMENTAL PLAN E

(Premiums as of May, 1994 for the California counties of San Diego, Orange, Los Angeles, San Bernardino, Imperial, and Riverside)

COMPARISON OF PREMIUMS OF ATTAINED-AGE MEDIGAP PLAN VERSUS STANDARD MEDIGAP COMMUNITY-RATED PLAN

Insurer and type of plan	Age of beneficiaries— 65–69 yrs. old	70–74 yrs. old	75–79 yrs. old	80+ yrs. old
Community-Rated Plan	$957	$957	$957	$957
AARP/Prudential plan Standard "Medigap" No restrictions on accessing beneficiaries' providers of choice				
Attained-Age Plan	780	1,080	1,260	1,380

COMPARISON OF PREMIUMS OF ATTAINED-AGE MEDIGAP PLAN VERSUS STANDARD MEDIGAP COMMUNITY-RATED PLAN—Continued

Insurer and type of plan	Age of beneficiaries— 65–69 yrs. old	70–74 yrs. old	75–79 yrs. old	80+ yrs. old
Blue Cross plan Medicare Select type Limited network of providers and restricted access to the limited network				
Cumulative difference in premiums of attained-age supplemental plan to community rated plan	−$177 X 5 yrs	+$123 X 5 yrs	+$303 X 5 yrs	+423 X 5 yrs
	−885	+615	+1,515	+2,115
Additional cost for a person living to the age of 85 who enrolls in an attained-age plan	.....	.....	.....	+3,360

Source: Senior World Newsmagazine, San Diego Edition, May, 1994, analysis conducted by the Office of Congressman Stark.

Because this legislation would accomplish the central goal of providing greater protections to Medicare beneficiaries, it has the endorsement of consumer and senior organizations. Two of the largest senior and consumer organizations made the following comments:

> Congressman Stark's proposed Medicare Beneficiary Protection Amendments of 1995 will institute needed protections in the Medicare Select program * * * it also strengthens protections for Medicare beneficiaries in other managed care options.—Testimony of the National Committee to Preserve Social Security and Medicare before the Committee on Ways and Means Subcommittee on Health, February 10, 1995.
>
> Consumers Union strongly supports the Medicare Beneficiary Protections Amendments of 1995. This Act would provide important protections for the Medicare beneficiaries who enroll in managed care plans, purchase Medicare Select policies, or purchase a medigap policy * * * [T]he protections will benefit tens of millions of senior citizens.—Consumers Union, May 8, 1995

I would like to complement my colleagues who are joining me today in introducing this bill. They have responded to the needs of their senior and disabled constituents—those who rely upon Medicare for their health insurance coverage. They have responded to the challenge to balance the goals of providing a broad range of coverage choices for Medicare beneficiaries while at the same time making sure that these choices do not place Medicare beneficiaries at risk.

I look forward to working with all my colleagues to move the Medicare Beneficiary Protection Amendments of 1995 forward. Due to the urgency of this issue, I hope we will not delay in taking up consideration of this legislation.

A summary of the bill follows.

MEDICARE BENEFICIARY PROTECTION AMENDMENTS OF 1995—SUMMARY (5/19/95)

I. MEDICARE MANAGED CARE BENEFICIARY PROTECTION PROVISIONS

A. Marketing standards

1. Plans could not market to beneficiaries on a door-to-door basis.

2. Plans could not require beneficiaries to attend an enrollment seminar and would be required to permit enrollment through the mail.

3. Commissions may not constitute the predominant source of compensation for agents.

4. To the extent an agent is compensated based upon a commission, the plan would be required to recover the commission if the

beneficiary disenrolled within 90 days after initial enrollment.

B. Due process requirements for providers in networks

1. Public notice would be required as to when applications by participating providers are to be accepted.

2. Descriptive information regarding the plan standards for contracting with participating providers would be required to be disclosed.

3. Notification of a participating provider of a decision to terminate or not renew a contract would be required not later than 45 days before the decision would take effect, unless the failure to terminate the contract would adversely affect the health or safety of a patient.

4. Notices would be required to include reasons for termination or non-renewal. Carriers would be required to offer providers receiving notification of termination or nonrenewal an opportunity for review of the reasons, with a majority of those conducting the review to be peers of the provider that have contracts with the managed care plan.

5. The findings of such a review would be advisory and non-binding. Federal or State laws pertaining to the right of involved parties to appeal or seek recourse would not be superseded.

C. Standards for utilization review would be established by the Secretary

1. Individuals performing utilization review could not receive financial compensation based upon the number of certification denials made;

2. Negative determinations about the medical necessity or appropriateness of services or the site of services would be required to be made by clinically-qualified personnel;

3. Utilization review procedures would be required to be based on reasonable, current medical evidence and applied consistently across reviewers and developed in consultation with participating providers;

4. Plans would be required to provide to enrollees a written description of the utilization review requirements of the plan.

D. Centers of excellence: Plans would be required to demonstrate that enrollees have access to designated centers of excellence

1. According to standards developed by the Secretary, plans would demonstrate that enrollees with chronic diseases or who otherwise require specialized services would have access to designated centers;

2. The Secretary would designate centers that provide specialty care, deliver care for individuals with chronic diseases or other complex cases requiring specialized treatment. Such centers must meet standards established by the Secretary pertaining to specialized education and training, participation in peer-reviewed research, and treatment of patients from outside the facility's geographic area.

3. Recognition of trauma centers: The existing requirements that plans provide for reimbursement of services outside the plan's provider network where medically necessary and immediately required because of an unforeseen illness, injury, or condition would be clarified to include services provided by designated trauma centers.

4. Ob-Gyn Referral: Plans would be prohibited from requiring enrollees to obtain a physician referral for obstetric and gynecologic services.

E. Access to emergency medical care

1. Plans could not require pre-authorization for emergency medical care.

2. A definition of emergency medical condition based upon a prudent layperson definition would be established to protect beneficiaries from retrospective denials of legitimate claims for payment for out-of-plan services.

3. Plans could not deny any claim for a beneficiary using the ''911'' system to summon emergency care.

4. Plans would be required to provide timely authorization for coverage of emergency services.

5. Plans would be required to reimburse fully emergency physicians for any services provided to beneficiaries in order to fulfill the requirements of the anti-dumping statute.

F. Deadline for responding to requests for coverage of services

1. Plans would be required to make a final determination within 24 hours;

2. Secretary would be required to establish an expedited process to review appeals of plan denials.

G. Nondiscriminatory service area requirements

1. In general the service area of a plan serving an urban area would be an entire Metropolitan Statistical Area (MSA). The Secretary could waive this requirement if the plan demonstrated that it could not develop capacity to expand to the entire MSA and that the plan's proposed service area boundaries to not result in favorable risk selection. The Secretary could not waive the requirement that the plan serve the central county of an MSA.

2. The Secretary could require a plan to contract with Federally-qualified health centers (FQHCs), rural health clinics, migrant health centers, or other essential community providers located in the service area if the Secretary determined that such contracts are needed in order to provide reasonable access to enrollees throughout the service area.

H. Contractors would be required to disclose information about physician payment

1. Information would be provided under the terms of the contract with the Health Care Financing Administration (HCFA).

2. Information would be made available to plan enrollees, or potential enrollees, upon request.

I. Intermediate sanctions on HMOs

1. Civil money penalties of up to $25,000 for each violation that directly or indirectly adversely affects an individual enrolled in the plan.

2. Civil money penalties of up to $10,000 for each week after the Secretary begins proceeding to terminate a contract.

3. A new formal process would be adopted through which HMOs could submit a corrective action plan for violations of the requirements. More severe penalties could be imposed on HMOs with previous deficiencies.

4. HMOs which fail to cooperate with PRO quality review and which fail to meet standards for appeals would be subject to existing intermediate sanctions and civil money penalties.

J. Amendments to Health Care Prepayment Plan under section 1833 (HCPPs)

1. The HCPP option would be restricted to organizations that could not qualify under section 1876 as an HMO such as the UMW and other union plans.

2. New requirements would be imposed on HCPPs: Solvency and marketing standards would be imposed; HCPPs would be required to meet the section 1876 standards for grievance procedures and physician incentive plan requirements, and would be subject to the section 1876 intermediate sanctions and civil money penalties.

3. The provision of the Social Security Amendments of 1994 which subjects HCPPs to the MediGap standards effective January 1, 1996 would be repealed.

4. A transition rule would be provided for beneficiaries enrolled in HCPPs which would not continue as a result of this provision.

K. Other beneficiary protections

1. An enrollee of an HMO receiving unauthorized out-of-plan treatment could not be charged more than what Medicare would have paid under fee-for-service rules.

2. Plans would be required to make arrangements for dialysis services for beneficiaries traveling outside the plan's service area.

L. Benefit package for section 1876 HMO plans

1. In addition to regular Medicare benefits, plans would be required to provide hospitalization and SNF coverage without the three-day stay requirement.

2. For Medicare covered services, plans may not impose cost-sharing other than nominal co-payments.

3. Limits on additional benefits (if any) must be fully explained and enrollees given reasonable notice that benefits are expiring.

4. Requirements to provide additional benefits to the extent that the plan's adjusted community rate is exceeded by the AAPCC payment would not change.

M. Plans would be required to provide information on provider credentials to enrollees and patient enrollees

N. A demonstration project on competitive rate-setting for Medicare risk contractors would be conducted

O. HMO outlier pool

An outlier pool would be created for HMOs with risk contracts to provide reinsurance for high-cost cases. The pool would be created by withholding a percentage of current payments.

P. PRO review

All section 1876 and section 1833 plans would be subject to PRO review.

II. MEDICARE SELECT PROVISIONS

The Medicare Select demonstration program would be amended:

A. Establish Federal oversight of Medicare Select

1. Secretary would establish standards for Medicare Select in regulation.

To the extent practicable the standards would be the same as the standards developed by the NAIC for Medicare Select plans. Any additional standards would be developed in consultation with the NAIC.

2. Medicare Select plans would generally be required to meet the same requirements in effect for Medicare risk contractors under section 1876: Community rating; prior approval of marketing materials; intermediate sanctions and civil money penalties; additional requirements added by this bill as described below.

3. If the Secretary has determined that a State has an effective program to enforce the standards for Medicare Select plans established by the Secretary, the State would certify Medicare Select plans. If the Secretary does not make such a finding with respect to a State, the Secretary would certify Medicare Select plans in that State.

4. Existing requirements for State-based standards and fifteen-State restriction would be repealed.

B. Benefit Requirements

1. Fee-for-service Medicare Select plans would offer either the MediGap ''E'' plan with payment for extra billing added or the MediGap ''J'' plan. Both have preventive benefits and adding extra billing benefits to ''E'' should not add cost given that network doctors should all accept assignment.

2. If an HMO or competitive medical plan (CMP) as defined under section 1876 offers Medicare Select, then the benefits would be

required to be offered under the same rules as set forth in Title III below. Such plans would therefore have different benefits than traditional MediGap plans.

III. MEDIGAP PROVISIONS

A. All MediGap policies would be required to be community rated.

B. MediGap plans would be required to participate in coordinated open enrollment.

C. The loss ratio requirement for all plans would be increased to 85 percent.

IV. COORDINATED OPEN ENROLLMENT

A. The Secretary would conduct an annual open enrollment period during which Medicare beneficiaries could enroll in any MediGap plan, Medicare Select, or an HMO contracting with Medicare.

1. Each Medigap plan, Medicare Select plan, and HMO contractor would be required to participate in the open enrollment system.

2. The Secretary would make available to beneficiaries information on Medigap and Medicare-contracting HMO plans.

B. Generally, except for cause, an enrollee could enroll, disenroll, or switch plans only during the annual open enrollment period, with the following exceptions:

During the first year of enrollment with a limited access plan (including HMOs and Medicare Select) the beneficiary could disenroll at the end of any calendar quarter and return to fee-for-service. During the second year, disenrollment could only occur mid-year at the end of the second calendar quarter. After the first two years, disenrollment could only occur during the open enrollment period;

There would be an exception for HMOs which the Secretary determines has reached capacity;

There would be an exception to individuals newly eligible for Medicare or who are new residents of the service area of a plan who could enroll on an open enrollment basis during the sixty-day period that begins thirty days before they become eligible or before they become a resident of the service area.

COMPREHENSIVE FETAL ALCOHOL SYNDROME PREVENTION ACT

HON. BILL RICHARDSON

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 24, 1995

Mr. RICHARDSON. Mr. Speaker, I am pleased to introduce the Comprehensive Fetal Alcohol Syndrome Prevention Act. Fetal Alcohol Syndrome [FAS] is the leading cause of mental retardation in the United States and is one of the most common birth defects to occur in our country. Diagnosis is rare prior to birth and there is no cure for FAS or Fetal Alcohol Effects [FAE], its less severe counterpart.

This disease is completely preventable, by simply avoiding alcohol during pregnancy, but the number of affected children is rising sharply. Recent studies indicate that the percentage of babies stricken by FAS has increased six-fold in the last 15 years.

The statistics are appalling: the disease affects 1 in 250 live births; 5,000 infants are born each year with the recognizable facial, physical and mental abnormalities caused by FAS; 50,000 babies are born annually with FAE, and suffer from learning disabilities, central nervous system damage, and physical disorders.

Not only are the emotional impacts of these diseases devastating, the costs associated with treatment are very high: health care costs for one child stricken with FAS total $44,000.

FAS and FAE strike without regard to race or economic status, but the rate of incidence is higher among certain groups; for instance, the rate is 30 times higher among Native Americans. This disease threatens to destroy whole generations on some reservations if stronger federal action is not initiated.

Surprisingly, much of the public is still unaware of the dangers of drinking during pregnancy. The medical community does not uniformly caution against alcohol consumption for pregnant women, and most medical schools do not provide curriculum on FAS prevention and detection.

This bill seeks to address each of these issues comprehensively. It requires the Department of Health and Human Services to close the gaps in our current efforts to prevent FAS and FAE by establishing a coordinating committee to streamline program development and eliminate duplicative research programs. The committee will develop professional practice standards and curriculum for health care providers, and will initiate a national public awareness program to outline the dangers of alcohol consumption during pregnancy. Finally, additional research will be conducted to aid detection and a cure for FAS so that future generations will not suffer from this debilitating disease.

This bill, as evidence by our bipartisan list of cosponsors, deserves the support of all Members, and I look forward to working toward its passage.

VIRGINIA R. SAUNDERS, 50 YEARS OF FEDERAL SERVICE

HON. STENY H. HOYER

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 24, 1995

Mr. HOYER. Mr. Speaker, I rise today to recognize Ms. Virginia Saunders, congressional document specialist at the Government Printing Office, for reaching 50 years of dedicated and enthusiastic Federal service on Friday, May 26, 1995.

Ms. Saunders was born Virginia R. Frisbie in Darlington, MD, on October 11, 1926. After working briefly at the Federal Bureau of Investigation, she came to the Government Printing Office on February 4, 1946, as a war service junior clerk typist in the division of public documents, stock section. Two years later, she was promoted to the division of public documents reference section. In February 1951, Ms. Saunders was promoted to indexing clerk and earned subsequent promotions in the same classification. In July 1958, she was promoted to library technician. Becoming a congressional documents specialist in April 1970, she was then promoted to supervisor of the congressional documents section in July 1974. In October 1983, Ms. Saunders assumed her current position of congressional documents specialist in the congressional printing management division, customer services.

Although one may not yet recognize the name of this outstanding GPO employee, the end product of her dedicated efforts is certainly familiar. Ms. Saunders has primary responsibility for the Congressional Serial Set, which is a compilation of all the House and Senate documents and reports issued for each session of Congress. Dummy volumes establishing the format for each edition are prepared and assigned a serial number following each session of Congress. The actual books are produced by GPO's binding division, often as many as 100 volumes per set for each session of Congress. As a chronicle of events of the U.S. Congress over the years, the Congressional Serial Set is rivaled only by the CONGRESSIONAL RECORD. While the Serial Set records behind-the-scenes legislative activities for the United States, the CONGRESSIONAL RECORD reflects the ''in session'' proceedings. Distributed to the House and Senate libraries, the Archives, the Library of Congress, and depository libraries, the Congressional Serial Set joins the CONGRESSIONAL RECORD in offering students and historians a rich insight into the American system of government.

In late 1989, Ms. Saunders drew upon her indepth knowledge of depository library program responsibilities in informing the Nation, and her then-43 years of GPO experience, to submit an employee suggestion regarding the appendix to the Iran Contra Report to Congress. She suggested that this 40-volume publication, which was printed as both a Senate and House report, be bound only once for the serial set volumes of House and Senate reports that are sent to depository libraries. She further suggested that the Schedule of Volumes, which is a listing of the bound volumes, contain a notation explaining the mission serial number voluments. The implementation of this suggestion resulted in a reduction of 13,740 book volumes to be bound, saving the Federal Government over $600,000. In recognition of these efforts, she received GPO's top monetary Suggestion Award for that year. In ceremonies held on January 9, 1991, Ms. Saunders was awarded a Presidential letter of commendation under the Presidential Quality and Management Improvement Award Program. In his letter to Ms. Saunders, President Bush noted, ''You have demonstrated to an exceptional degree my belief that Federal employees have the knowledge, ability, and desire to make a difference.''

I know my colleagues and Ms. Saunders' family, friends, and coworkers join me in congratulating her on 50 years of exemplary Federal service.

CONGRATULATIONS TO THE SHELTER ISLAND HEIGHTS POST OFFICE

HON. MICHAEL P. FORBES

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 24, 1995

Mr. FORBES. Mr. Speaker, I rise today to praise the exceptional service provided by the Shelter Island Heights Post Office. For the past 115 years, the Shelter Island Heights Post Office has served the community with extreme dedication. I would also like to commend the Shelter Island ferry service which has provided the vital link between the mainland and Shelter Island. This ferry service has been at the heart of the Postal Service for the Shelter Island Heights community. With the help of this ferry service, the Shelter Island Post Office has been able to deliver over 1.5